STATE OF TENNESSEE
EMPLOYEE SICK LEAVE BANK
FIRST FLOOR, JAMES K. POLK BUILDING
505 DEADERICK STREET
NASHVILLE, TENNESSEE 37243-0635
TEL. (615) 741-5431 1-800-221-SEIL (7345)
FAX (615) 401-7667

FOR SLB USE ONLY

Agency Budget Code: _____

Status: _____ Hrs. _____ Yr. _____

Hours Previously Used: _____

Leave Expires: _____ Hrs: _____

7.5 ____ 8.0 ____ S ____ D ____

WITHDRAWAL REQUEST APPLICATION

Please complete and submit this Withdrawal Request Application through your personnel office. The Sick Leave Bank must receive this application no earlier than two weeks prior to the expiration of all accumulated sick, compensatory and annual leave, but no later than thirty (30) days after the expiration of all accumulated leave.

Employee's Name: Last _____ First _____ Home Phone # (___)_____

Employee's Social Security Number: _____ DOB: _____ _____ _____
Month Day Year

Home Address: _____ City _____ State _____ Zip _____

Employee's Department and Position Title: _____

Have you previously received sick leave from the Sick Leave Bank? ..... Yes ___ No ___

Name used during previous withdrawal if different from present name: _____

1) My absence is due to _____
   My first day absent due to this condition was _____

2) Is this a work-related injury or illness? From state employment: ..... Yes ___ No ___
   From other employment: Yes ___ No ___ If yes, employer name and date: _____

3) Have you filed a Worker's Compensation claim with the Division of Claims or through other employment? Yes ___ No ___

4) Have you applied for Social Security disability? Yes ___ No ___ Date applied: _____

5) Are you currently approved for or receiving Social Security disability? Yes ___ No ___ If yes, effective date: _____

6) Have you applied for retirement through the Tennessee Consolidated Retirement System? ..... Yes ___ No ___
   If yes, check one. ___ Early Disability Retirement ___ Service Retirement Date requested: _____

7) Are you currently receiving income from other employment? .... Yes ___ No ___

I provided my medical doctor/surgeon with a Medical Certification Form to confirm my illness or injury as required by the Sick Leave Bank ("SLB") Guidelines. I instructed my medical doctor/surgeon to send the completed form directly to the SLB at the address listed at the top of the form. I understand that leave grants from the SLB shall not exceed more than twenty (20) consecutive days per application. I understand that the maximum number of days a member receives for an accident, illness, or an illness related to, resulting from, or recurring from a previously diagnosed illness is ninety (90) days. In addition, leave grants shall not exceed ninety (90) days within a twelve (12)-month period as defined in the guidelines.

I certify that the information given in this application is correct and complete to the best of my knowledge. I am aware that should investigation show any material misrepresentation of facts, I will not be considered for SLB benefits. The SLB Board of Trustees may remove me from the SLB, and I may be subject to disciplinary action up to and including dismissal. I hereby authorize the SLB to make all necessary investigations concerning this application. I further authorize and request any records or information, including but not limited to medical, Workers' Compensation, State Retirement or Social Security disability, that is sought in connection with this application be provided to the SLB.

_____ _____
Signature of Employee or Legal Representative and Date Signature of Personnel Officer and Date

Determination of initial applications made within ten (10) days from receipt of all necessary documentation.